STATEMENT

of the

American Medical Association

to the

Committee on Ways and Means
Subcommittee on Health
U. S. House of Representatives

RE: Reforming Medicare's Physician Payment System

Presented by: Nancy H. Nielsen, MD, PhD

September 11, 2008

Division of Legislative Counsel
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The American Medical Association (AMA) appreciates the opportunity to provide our views on "Reforming Medicare's Physician Payment System." We commend you, Chairman Stark, Ranking Member Camp and Members of the Subcommittee for your strong efforts and recognition of the critical need to reform the Medicare physician payment system.

We are grateful to Congress for enactment of H.R. 6331, the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA), which averted a 10.6 percent cut in Medicare physician payment rates, extended the 0.5 percent payment update through December 31, 2008, and provided a 1.1 percent payment rate update for 2009. This provides an 18-month window of opportunity to develop a solution to the Medicare physician payment formula, based on the flawed sustainable growth rate (SGR), and we applaud the Subcommittee for taking an immediate first step in holding this hearing. We also look forward to collaborating with the Subcommittee and Congress in designing a system that is fair to physicians and patients and that strengthens the Medicare program.

THE MEDICARE PHYSICIAN PAYMENT FORMULA IS FATALLY FLAWED

The Medicare physician payment formula is broken. The SGR is linked to factors that do not correlate to medical practice cost inflation, nor does the SGR take into account significant contributors to utilization growth in physicians' services, such as technological advances and shifts in care from the hospital to physician office, that are beyond physicians' control. Yet, when Medicare utilization of physicians' services exceeds the SGR target, physicians are unfairly penalized with steep cuts in their payment update. As a result of the flawed SGR, since 2001, Congress has repeatedly had to scramble at the 11th hour to forestall steep cuts in the Medicare physician payment rate. Despite these interventions, physicians face over 40 percent in cuts over the coming decade. Physicians cannot absorb these steep losses, especially when data released by the Centers for Medicare and Medicaid

Services (CMS) shows that physicians currently are only being reimbursed for two-thirds of the labor, supply and equipment costs that go into each physician service.

MEDICARE PHYSICIAN PAYMENT POLICY REFORMS NEEDED TO PRESERVE MEDICARE FOR FUTURE GENERATIONS

The Congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 physicians by 2020. Other studies forecast shortages in a number of specialties, including primary care, cardiology, emergency medicine, general surgery, geriatric medicine, oncology, neurosurgery and thoracic surgery. Multi-year cuts in Medicare are nearly certain to exacerbate these shortages by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older. Further, in the face of continuous projected cuts, the current physician payment system undermines policymakers' vision of a Medicare health care system that uses health information technology (HIT), as well as quality initiatives, to deliver the highest quality of care to Medicare patients. These initiatives require significant financial investment by physicians, and it is neither practical nor feasible to transition to a system that uses important initiatives, such as HIT and electronic medical records, when physicians, especially those in small practices, must first ensure that they can keep their doors open in the face of steep Medicare physician cuts.

To fulfill policymakers' vision of an HIT-based health care system, as well as prevent a serious physician shortage, Congress must ensure that Medicare payments are premised on a stable physician payment system that provides positive annual updates and accurately reflects increases in medical practice costs.

Further, since the SGR is not realistically linked to actual growth in utilization of physicians services, it sets up a continuous false picture of spending on physician services. This fallacy has been compounded by CMS, which has inappropriately included certain health care costs under the SGR that have exacerbated the problem. For example, if CMS had removed from its calculations of spending on physicians' services the costs of physician-administered drugs, as Congress repeatedly assured CMS it had the authority to do, we estimate that the budgetary score for replacing the SGR with MEI updates would be reduced by half. We also believe that CMS is required by law to adjust its estimates of allowable spending growth to reflect the impact of Medicare's own coverage expansion decisions, but CMS has declined to do so.

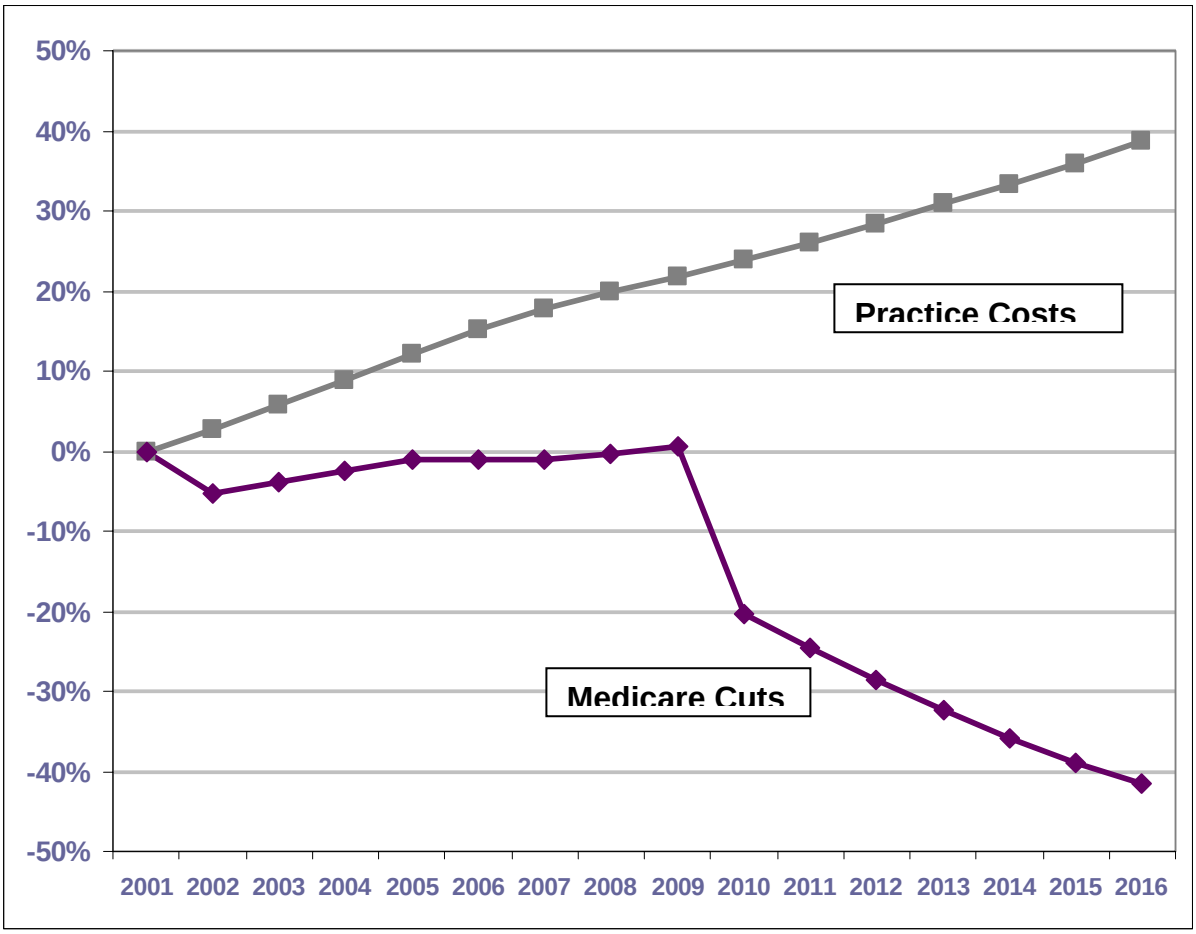
We urge the Subcommittee and Congress to address the projected spending fallacy presented by the current SGR baseline. One part of the SGR solution Congress should consider is rebasing the SGR. In the past seven years, Congress has repeatedly determined that the existing SGR baseline would result in harmful payment cuts and enacted legislation to override the SGR formula. In fact, half the cuts that are forecast are due to the way these legislative interventions were financed, and not due to the rate of growth in spending exceeding the SGR targets. The SGR baseline has been rejected on a broad bipartisan basis in both Houses of Congress. Rebasing the SGR would simply formally recognize these Congressional interventions, more accurately reflect projected Medicare spending and establish a rational basis for a reformed payment system that provides appropriate incentives to address value, utilization and quality of care.

MEDICARE PHYSICIAN PAYMENT REFORM IS NEEDED NOW

Due to the SGR, as discussed above, Congress has repeatedly had to provide 11th hour interventions to forestall steep Medicare physician payment cuts. Moreover, despite good intentions to do otherwise, Congress ultimately has had to use a financing mechanism in the last several interventions that results in deeper and deeper projected cuts for each subsequent year, thus making each legislative fix more costly and difficult to enact than the previous one.

Even with these well-intentioned Congressional efforts, Medicare's conversion factor is less than it was in 2001, and, as discussed above, physicians face over 40 percent in cuts in the coming decade. Yet, even by the government's own conservative estimate, physician practice costs will increase nearly 20 percent during this time period. To compound matters even more, once Medicare implements a payment rate cut, it has a ripple effect as other payers that tie their rates to Medicare (including Medicaid, TRICARE, and various private payers) follow suit.

The chart below shows the gap in Medicare payment to physicians from 2001 through 2016, as compared to increases in medical practice costs, as measured by the government's own Medicare Economic Index (MEI).



Note: Physician cost data is from the MEI, a conservative measure of practice cost growth maintained by CMS. Medicare cuts are from the 2008 Medicare Trustees report, with adjustments to reflect Sec. 131 of P.L. 110-275.

Physicians have shouldered a disproportionate burden for restraining Medicare spending. While physicians have been receiving below-inflation updates or a payment freeze, other Medicare providers' payment updates have kept pace with or exceeded their costs increases. For example, Medicare Advantage (MA) plans' payment rates have risen 32 percent since the program began in 2004. There is no rational basis for the significant disparity in updates for other providers and the steep payment rates cuts slated for physicians. Physicians and other health care professionals should have payment updates that keep pace with their cost increases, similar to the updates for other providers.

Numerous surveys project a crisis in patient access if Medicare payments fall further behind practice cost increases:

- In an AMA survey, 60 percent of responding physician said they would have had to limit the number of new Medicare patients they treat if this year's pay cut had not been stopped. Further, more than half of the surveyed physicians said they could not have met their current payroll with a 10 percent Medicare pay cut and would have been forced to reduce their staff.

- The Medicare Payment Advisory Commission (MedPAC) reports that 30 percent of Medicare patients looking for a new primary care physician already have trouble finding one.

- The Medical Group Management Association found that 24 percent of group practices already limit their acceptance of new Medicare patients.

The projected cuts also affect physician workforce issues. As discussed above, a serious physician shortage is expected by 2020, and an Association of American Medical Colleges workforce study found that 51 percent of physicians over 50 cite "insufficient reimbursement" as a "very important" factor in retirement decisions.

It is especially important that Congress act now to stabilize the Medicare program considering that the first wave of baby boomers will begin entering the Medicare program in 2011, with enrollment growing from 44 million in 2011 to 50 million by 2016. **Thus, the time is now for Congress to repeal the SGR and enact broad-based reform of the Medicare physician payment system.**

CURRENT AMA INITIATIVES TO ADDRESS PHYSICIAN PAYMENT REFORM

The AMA is actively committed to working with congressional leaders, the committees of jurisdiction, the new Administration and MedPAC to adopt and implement new payment policies that provide appropriate incentives to address the value, utilization and quality of care delivered to Medicare beneficiaries.

While we are not poised at this time to identify any single solution to the challenge of Medicare physician payment, the AMA is actively working with the physician community to move forward with alternative physician payment reforms that will have a broad base of support. We look forward to sharing more specific comments with the Subcommittee on these matters as our efforts proceed.

In the meantime, the AMA supports physician efforts to develop and implement clinical practice guidelines that promote appropriate utilization of services. As a key element toward achieving broad-based payment reform, we urge Congress to support funding for quality comparative effectiveness research that will improve health care value by enhancing physicians' clinical judgment and fostering the delivery of patient-centered care.

The AMA is also very aware that threats to the sustainability of the Medicare program have heightened policymakers' concern about growth in the volume of Medicare physician services. Some even have argued there is little evidence that patients benefit from increases in service utilization. We take such concerns very seriously. We also believe, however, that it is important to understand the reasons underlying changes in the utilization of specific services and categories of services, rather than applying across-the-board pay cuts based on an arbitrary volume growth target.

For the last several years, we have engaged clinical experts in analyzing emerging trends in utilization and identifying the various factors behind those trends. Based on this analysis, we now know that per beneficiary utilization growth for physicians' services fell to 3 percent in 2007, down from 4 percent in 2005 and 2006 and 6 percent in 2004. The 2008 Medicare Trustees report found similar trends, indicating that annual volume growth in Medicare physician services for 2005 and 2006 was half the growth rate that the Trustees projected in their 2006 report. These trends are due to such factors as a reduction in hospital and emergency room visits as physicians manage more patients in their offices. The growth rate for imaging services has also slowed significantly. The AMA is committed to continuing our efforts to analyze and take steps to help slow utilization growth.

We support the MIPPA provision requiring the Secretary of the Department of Health and Human Services (HHS) to implement a program by January 1, 2009, that provides physicians with confidential feedback reports on utilization of resources in furnishing care to Medicare patients. We understand that CMS is planning to begin with a limited number of conditions and test various designs as it initiates these feedback reports. For example, many episodes of care will involve services from several physicians and there are various theories as to which costs should be attributed to which physician. It is our understanding that CMS intends to test several different approaches, including some that attribute all cost to a single physician and some that would distribute costs among several physicians. We appreciate CMS' willingness to explore potential problems and test different solutions before broad implementation.

Further, the AMA/Specialty Society RVS Update Committee (RUC), in collaboration with CMS, is currently undertaking a review of physicians' services that are potentially misvalued. The RUC agrees with MedPAC that accurate payment can help ensure appropriate utilization. Since October 2006, the RUC has identified more than 320

potentially misvalued services, and has recommended reductions in work and/or practice expense values for 108 of these services. Many of the remainder of these services will require coding changes prior to any assessment of the valuation. The RUC is also assembling data on CMS' list of the 114 fastest growing services and has distributed the data to all specialty societies. The RUC is soliciting plans of action to address each of these services during its October 2008 meeting for action during the upcoming RUC recommendation cycle. Moreover, the RUC plans to review physicians' services that are commonly performed on the same day and make recommendations to CMS for a more efficient combined coding structure with respect to these services.

ALTERNATIVE PHYSICIAN PAYMENT REFORM APPROACHES

The AMA is working with other groups within organized medicine to explore other approaches intended to develop incentives for appropriate utilization, value and quality of care. Some of these approaches, which Congress and policymakers are also studying, include medical homes, quality reporting, bundling of services and accountable care organizations. Before finalizing our views on new reform proposals, it is important to garner widespread physician input, cooperation and consensus because all of these proposals can have significant advantages as well as disadvantages, with varying impact on physicians depending on many factors, such as medical specialty or size of practice.

For example, a fee-for-service system ensures that physicians have no incentive to withhold needed care, but does not encourage physicians to be judicious about the services they provide. In contrast, bundling payments provides more incentives for efficient care but also carries the risk that appropriate services are withheld or limited. The concept of bundling payments is complicated and encompasses many different possibilities, including the current bundling of physician surgical services and the much broader concept of coupling physician and hospital services in a single payment. While the AMA agrees with the need to provide appropriate incentives for physicians and hospitals to work together to deliver cost-effective, efficient and quality care, many elements of bundling must be addressed before implementing it on a broader scale. These elements include such critical matters as how to attribute care to individual providers, and risk-adjustment to appropriately pay for patients whose care exceeds what should be included in the bundled amount. Further, it will be important to ensure that decisions about patients' care remain in the hands of those who provide that care. Physicians must be able to tailor such care to the needs of individual patients, whose care often is influenced by such factors as whether a patient has a good family support network, can afford a particular medication or is capable of following a particular treatment regimen. **The AMA would support the development of demonstration projects that will help refine and determine those approaches to bundling that hold the most promise for all involved.**

Further, other policy reform proposals being discussed aim to provide incentives to physicians and hospital medical staffs to improve hospitals' clinical performance and quality outcomes and reduce their costs. These incentives can include directly paying for improved value or sharing a portion of the hospital cost savings based on the physicians' discrete, identifiable contributions toward these goals. The AMA believes that there are both significant benefits and risks associated with these approaches and it is important to design them carefully to: optimize the benefits and minimize the risks in order to facilitate

collaboration between physicians and hospitals; promote efficiency through greater access to needed services, quicker turn around time on procedure scheduling, and test results; provide new sources of funds to support quality initiatives; add incremental payments to augment physician fee schedules; return responsibility for the quality of patient care to physicians through their hospital medical staffs; improve the financial health of hospitals; and reduce the rate of growth in Medicare costs. It is important to design demonstration projects that will indicate how payment reforms can best achieve these goals while also ensuring that the new approaches avoid: achieving short-term cost savings at the expense of long-term health; limiting access to the most appropriate care; decreasing clinician control over patient care decisions; or penalizing physicians who treat resource-intensive patients with severe disabilities and chronic health conditions.

Further, the AMA, along with the entire federation of medicine, has made significant strides in facilitating federal and private quality improvement initiatives and we are vitally committed to continuing in these efforts. Finally, AMA policy firmly supports the concept of medical homes for improving chronic care, and we have also supported payment for care coordination and care management. Earlier this year, a RUC work group conducted weekly meetings to provide CMS with timely recommendations on how services in its upcoming medical home demonstration should be valued. If CMS adopts those values and moves ahead with the demo and a wider pilot authorized under MIPPA, primary care physicians should receive significant financial support for additional care coordination activities that will reduce fragmentation and improve medical treatments for millions of Americans with multiple chronic illnesses.

The success of any of the above reform proposals is also largely dependent on a well-developed risk adjustment methodology. Without adequate risk adjustment under these reform proposals, there can be unintentional adverse consequences for patients. For example, some cost containment and quality reporting programs can encourage patient de-selection for individuals at higher-risk for illness due to age, diagnosis, severity of illness, multiple co-morbidities, or economic and cultural characteristics that make them less adherent with established protocols. Yet, current risk adjusters do not generally adjust for factors such as obesity and smoking, and are not precise enough to identify certain complex patients. While the law of averaging may mitigate these weaknesses in payment systems applied to hospitals and health plans, they do not work as well at the individual physician level and have the potential to label physicians who specialize in treating the most difficult patients as inefficient. This will result in the physician being penalized through lower payments and/or patients being penalized with higher co-pays or facing limits on access to care. **To overcome these barriers, we urge the Subcommittee and Congress to direct CMS to work with federal policymakers, physician specialties and private entities to improve current risk adjustment techniques.** The comparative feedback reports that this Subcommittee recommended, and that CMS will be implementing next year, may help identify condition-specific factors that could enhance risk adjustment techniques as well as help physicians and policymakers identify problems such as inappropriate coding practices that could be addressed to constrain costs.

CONCEPTS CONGRESS SHOULD CONSIDER IN DEVELOPING BROAD-BASED PHYSICIAN PAYMENT REFORM

As the Subcommittee, Congress and other policymakers debate physician payment reform proposals, we urge consideration of the following important factors:

- There is not one single magic solution to the SGR problem. Various reforms may be needed to achieve the appropriate incentives for the delivery of quality, cost-effective care. **Some reforms may be ready for immediate implementation, while others may require more time to develop and implement effectively.**

- **Physicians want to work with Congress and CMS to curb any care that can be shown to be inappropriate.** Not all growth in the utilization of physician services, however, should be viewed as inappropriate care. Many factors that are outside of physicians' control drive utilization growth in physicians' services. For example, increased life spans, rising rates of costly but treatable chronic conditions (such as obesity, diabetes, kidney failure and heart disease), medical advances and unprecedented drug development all result in higher use of physicians' services. There are also laudable developments encouraged by the government through expanded benefits for Medicare. Mortality rates in this century have been falling by about 3 percent a year for heart disease, stroke, and other cerebrovascular disease, while deaths from cancer have declined by about 1 percent a year over the last decade.

- **It is time to examine all of the factors affecting physician practice costs, and adequately account for those costs in the Medicare physician payment system.** The physician payment system does not take into account physician investment in important initiatives such as HIT and electronic medical records. Widespread HIT adoption could transform the practice of medicine. A study by Robert H. Miller and others put the per physician cost of these systems at approximately $44,000 for the initial installation and about $8,500 per year thereafter. (Health Affairs, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider. Clearly, it is not practical or feasible for the many small and solo physician practices to transition to HIT (and electronic medical records) when they face steep payment cuts under the SGR that threaten the viability of their practices.

  Other important factors also affect practice costs. The current MEI measures increases in the prices of particular inputs used in physician practices. The actual composition of the inputs themselves, however, has not changed since the MEI was established in 1973. For example, the number of staff needed per physician has risen dramatically since the 1970s, but the MEI only takes into account increases in wages and benefits. **Accordingly, CMS should evaluate whether the inputs to the MEI accurately reflect the practice of 21st century medicine.** Further, in establishing the MEI each year, CMS adjusts it downward to account for assumed physician productivity increases. In 2008, the MEI is 1.8 percent, or just a little more than half of what it would have been if CMS had not included a 1.4 percent productivity

offset. With physicians spending more and more time and resources on administrative requirements, there is little opportunity to increase productivity. A productivity adjustment is not applied to the hospital or nursing home market basket, nor any other Medicare provider. **We have urged CMS to reevaluate the productivity adjustment to the MEI, but CMS has declined to do so. We urge the Subcommittee to press CMS to evaluate the productivity adjustment to the MEI and reduce or eliminate it accordingly.**

- **Payment reforms should be designed in a way that will improve coordination of care and accountability in Medicare. Further, mechanisms must be in place to ensure that Medicare fiscal resources are better coordinated and appropriately distributed among the current Medicare silos, *i.e.*, Medicare Parts A, B, C and D, especially to reflect the impact of initiatives that rely on physicians to provide more care in their offices to avoid costly hospitalizations.**

- **It is critical that the physician community and Congress work together to encourage healthy lifestyle choices that assist in long-term and costly disease prevention. Controlling these costs will also help reduce the increased utilization of physicians' services that results when an individual becomes eligible for Medicare at age 65.** In congressional testimony, Bruce Steinwald, Director of Health Care for the Government Accountability Office (GAO), has cited research by Kenneth Thorpe attributing 27 percent of the growth in inflation-adjusted per capita spending between 1987 and 2001 to the rising prevalence of obesity and higher relative per capita spending among obese individuals. The AMA has initiated many programs aimed at healthy lifestyles for disease prevention, and we will continue our efforts to address this important matter.

- When CMS revises the relative value units (RVUs) for physicians' services (which is a significant factor in determining payment for each service), by law, CMS must implement these RVU adjustments on a budget neutral basis. This means any increases in RVUs for certain services must be offset with decreased RVUs for other services. These decreases often apply across-the-board to all or many physicians' services, including the services that have been scheduled to receive an increase in their RVUs, thereby undermining the value of the increase.

  Further, in the past, Congress has legislated reductions to certain procedures and mandated that these reductions cannot be offset with increases to other services. In other words, these dollars were permanently removed from the physician payment pool. CMS has also chosen to implement certain legislative provisions in a manner that permanently removed dollars from the physician payment pool. This budget neutrality restriction, and the manner in which it has been implemented, complicates efforts to increase payments for primary care and other services that are generally recognized as undervalued. **We urge the Subcommittee and Congress to address the budget neutrality restriction as part of Medicare physician payment reform.** In addition, it is not reasonable to expect that certain payment reform proposals that increase payments for certain services should be made on a budget neutral basis since this only serves to reduce the value of all services. **Thus, as we move forward**

with physician payment reforms, we urge the Subcommittee and Congress to refrain from implementing any such reforms on a budget neutral basis.

- We appreciate that MIPPA contained provisions to help level the playing field between fee-for-service Medicare and MA plans. As shown by a September 5, 2008, report by the Commonwealth Fund, however, there still is much work to do to achieve a more complete level playing field. Payments to private MA plans will total $8.5 billion more than those for traditional fee-for-service plans in 2008, according to the report. Private MA plans will be paid at a rate 12.4 percent higher than for traditional fee-for-service Medicare, or an average of $986 more per enrollee, according to the report. According to Brian Biles, lead author of the report, Medicare Advantage was intended to save money through the use of private plans, but extra payments to these plans combined with rapidly increasing enrollment, has resulted in $33 billion in additional spending over five years. **We urge the Subcommittee and Congress to continue its efforts to achieve a level playing field between MA plans and fee-for-service Medicare. This is necessary to achieve fair competition, efficiencies among MA plans and equitable treatment of all Medicare beneficiaries.**

The AMA appreciates the opportunity to provide our views to the Subcommittee concerning Medicare physician payment reform. We look forward to working with the Subcommittee and Congress over the next 18 months to achieve a solution to the fatally flawed SGR as this is critical for ensuring that our seniors and disabled patients have access to a health care system that provides them with high quality, cost-effective care.